

# **Patient-Centered Medical Home and the Future of Medical Care in Montana**

**A series of Webinars for the Primary  
Care Providers of Montana created and  
presented by the Primary Care Providers  
of Montana**



# **Why a Patient-Centered Medical Home?**

**...or why am I feeling so overwhelmed with even more to do?**

# **Why Patient-Centered Medical Homes?**

**What are the problems they solve?**

- **Increased Work Demands**
- **Declining Numbers in Primary Care**
- **Low Provider Satisfaction**
- **Low Quality Health Care**

# **What is the Problem?**

## **INCREASED WORK DEMAND**

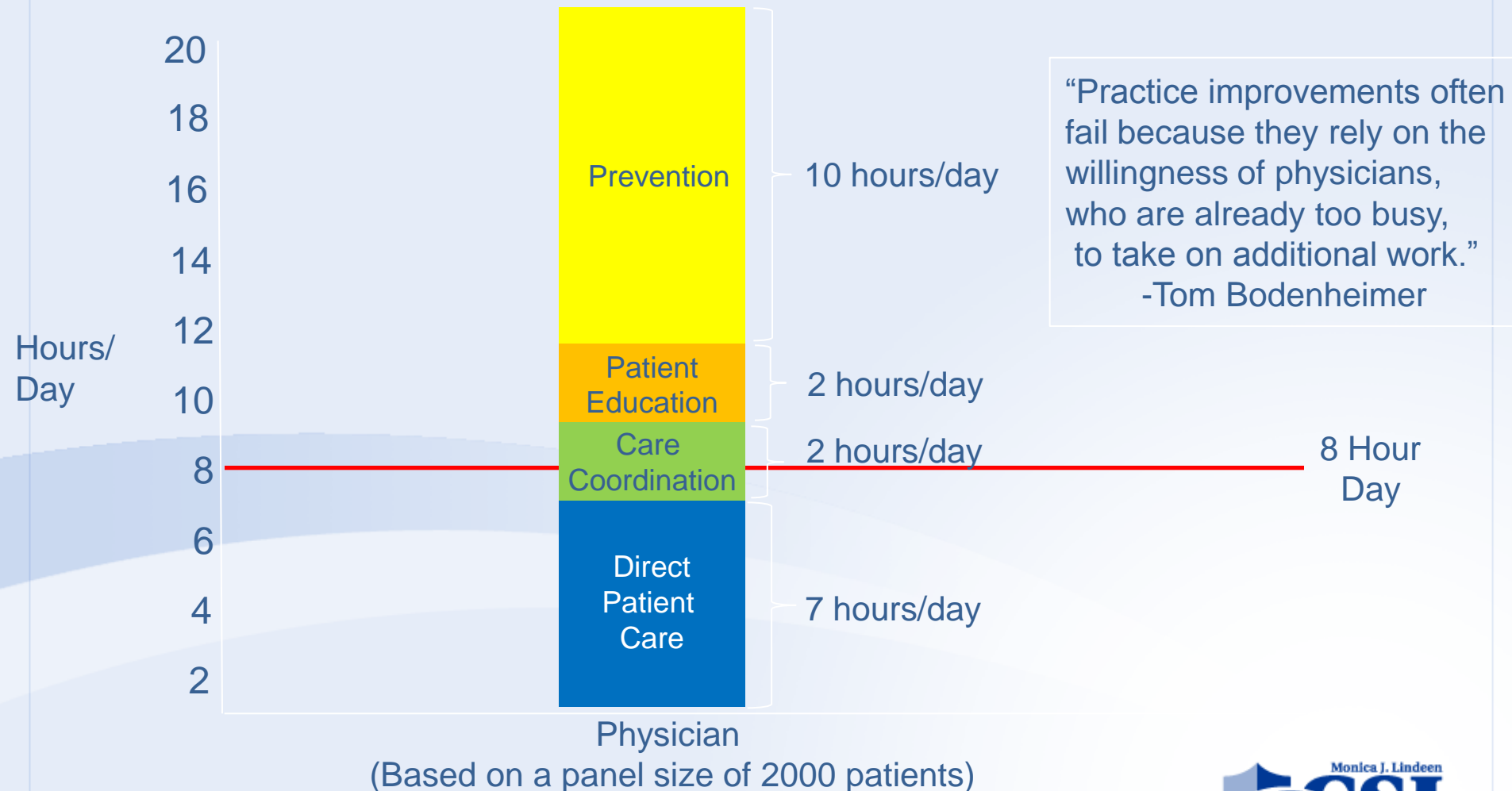


# Why is it so hard to be a PCP in 2012?

- Changing demography and practice content increasing demand
- Greater care complexity
- Declining real income
- Working harder and harder just to keep up
- Expected to do more and more



# *Without a team and a system, the burden of delivering safe care is virtually impossible*



# **Current Economic and Political Landscape**

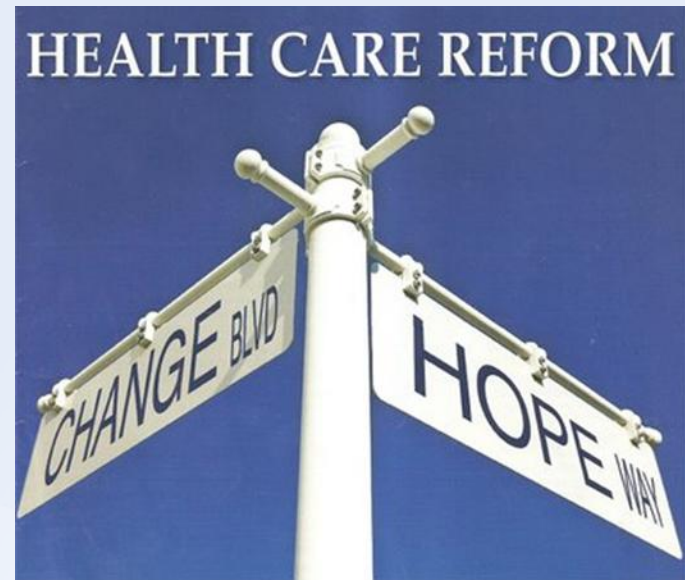
## **THE PATIENT PROTECTION AND AFFORDABLE CARE ACT**



# It is an interesting time for Primary Care in America

- Federal healthcare reform is counting on a robust primary care sector to improve quality, reduce costs, and improve patient experience (the triple aim).

**“The Patient Protection and Affordable Care Act (PPACA) of 2010 brings both promise and peril for primary care. This Act has the potential to reestablish primary care as the foundation of US health care delivery.”\***



# Reform Implications for Montana and Primary Care

- 35-40% of uninsured will become eligible for Medicaid = doubling by 2019.
- Aging population with increased need for complex medical services + large number of newly insured who will need PCP

**THIS SHOULD BE THE TIME FOR PRIMARY CARE TO RISE!**

# **What is the Problem?**

## **DECLINING PRIMARY CARE PROVIDER NUMBERS**



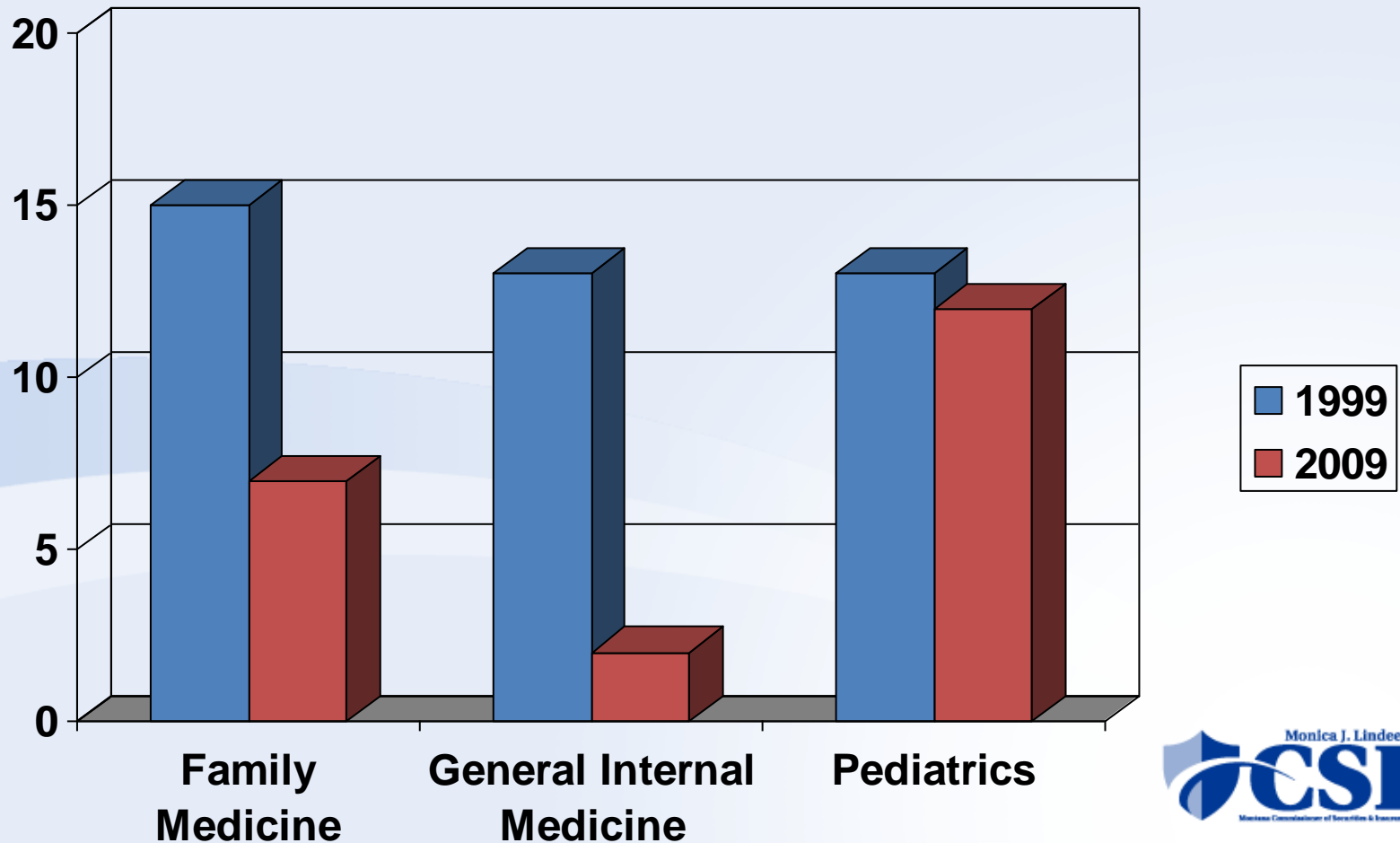
# Primary Care Importance

- Data has confirmed what we know: patients want a doctor who knows them and can help coordinate their care.
- Countries with better primary care have better health outcomes and lower costs.
- States with higher primary care/population ratios have lower costs and better quality.\*
- Fewer Graduates are entering Primary Care

- Shortage of Primary Care Physicians and cohort rapidly diminishing in size
- Evolving physician and patient culture
- The current model of care does not enable us to practice optimal care
- Our systems and processes do not enable us to practice at national standards of care or production.
- We are changing and so are our patients ~ we are operating with old systems in a new “society.”

# Diminishing?

Percentage of medical students choosing primary care specialties



# What is the Problem?

## LOW PROVIDER WORK SATISFACTION

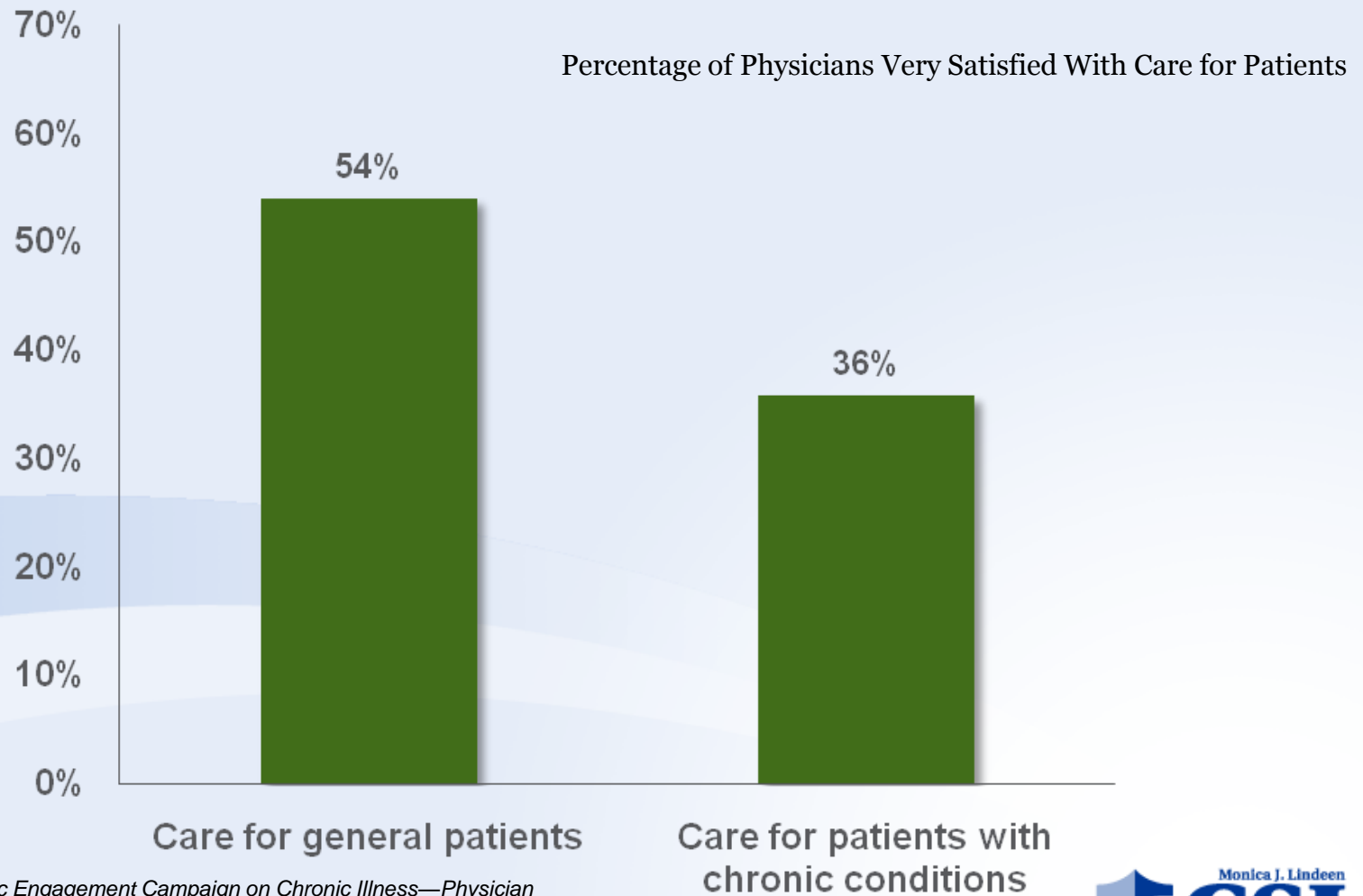


# Primary Care Morale

- 36% of US PCPs are not satisfied with practicing medicine compared to 11-12% in Norway, New Zealand, or Netherlands, and 19% in the UK.

*Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.*

# Physicians Are Less Satisfied Providing Care to People With Chronic Conditions



Source: *National Public Engagement Campaign on Chronic Illness—Physician Survey*, conducted by Mathematica Policy Research, Inc., 2001.

# Provider Joy in Work—the Fourth Aim?\*

- Provider dissatisfaction:
  - Reduces patient satisfaction;
  - Increases risk of retirement or reducing hours;
  - Increases turnover and reduces continuity;
  - Contributes to staff unhappiness; and
  - May increase costs.

This should be a strong motivator for change.

*\*Wagner, MacColl Institute for Healthcare Innovation,  
Group Health Research Institute*

# What is the Problem?

## LOW MEDICAL CARE QUALITY



# Health Care Quality

- Low quality is NOT a provider knowledge problem
- The problems with health care quality are related to the delivery system

# Quality today?

**“...adults receive 54.9 percent of recommended care....**The deficits we have identified in adherence to recommended processes for basic care pose serious threats to the health of the American public. Strategies to reduce these deficits in care are warranted.”

*McGlynn, et al, NEJM 348;26 June 26, 2003*

# Quality today?

- Only 46% of US PCPs have an EMR compared to 95+% in the Netherlands, UK, and New Zealand.
- Only 30-40% of US PCPs have the capacity to generate a list of patients with a disease or generate a drug list compared with the majority of MDs in most other developed countries.
- Only 29% of US PCPs have arrangements for patients to see a provider after hours compared to 89% or more in Netherlands, NZ, and UK.
- Less than 50% of US PCPs have data on the quality of their care.
- 59% of US PCPs use non-physician staff for patient care compared to 98% in the UK and Sweden.

*Source: 2009 Commonwealth Fund International  
Health Policy Survey of Primary Care Physicians.*

# What is a Medical Home?

## MONTANA'S DEFINITION



# Characteristics of medical homes

- Measures and improves Patient Satisfaction
- Measures and improves Access to Care
- Provides Care coordination and follow-up
- Provides Long term care continuity
- Provides comprehensive primary care services
- Measures and works to improve Population Health
- Team Approach to Health Care
- Changes in the Delivery System

***In Montana, a patient centered medical home is health care directed by primary care providers offering family centered, culturally effective care that is coordinated, comprehensive, continuous, and, when possible, in the patient's community and integrated across systems. Health care is characterized by enhanced access, an emphasis on prevention, and improved health outcomes and satisfaction. Primary care providers receive payment that recognizes the value of medical home services.***

# Recognition of Medical Homes

- Lots of Standards Groups
  - NCQA 2008 and 2011
  - URAC
  - Joint Commission
  - Accreditation Associate for Ambulatory Health Care
  - TransformMED
  - Center for Medical Home improvement
- Montana Recommends NCQA Standards

# National Committee for Quality Assurance (NCQA)

- Dedicated to improving health throughout the system
- Works with policymakers, doctors, patients and health plans to decide a formula for improvement: Measure. Analyze. Improve. Repeat.
- Develops quality standards and performance measures or use by health care organizations
- Standards promote strategies that will improve care, enhance service, and reduce costs
- [www.ncqa.org](http://www.ncqa.org)

# Montana Recognition Standard

## Final recommendation

Allow 2008 level 1 standard until Jan 2013

By Jan 2013 Require

Level 2 or 3 of the 2008 Standard

Level 1 or 2 or 3 of the 2011 Standard



# WHAT A MEDICAL HOME IS NOT!

- Gate Keeper Model of the 1990s
- Better educated providers
- Purely Capitated Payment system
- A cost containment strategy



# Meeting the Triple Aim

- The future of primary care (and our healthcare system) depends upon its ability to improve quality (first aim) and reduce costs (second aim), especially for the chronically ill.
- It will also require a recommitment of primary care to meet the needs of patients for timely, patient-centered, continuous and coordinated care (third aim--improve patient experience).

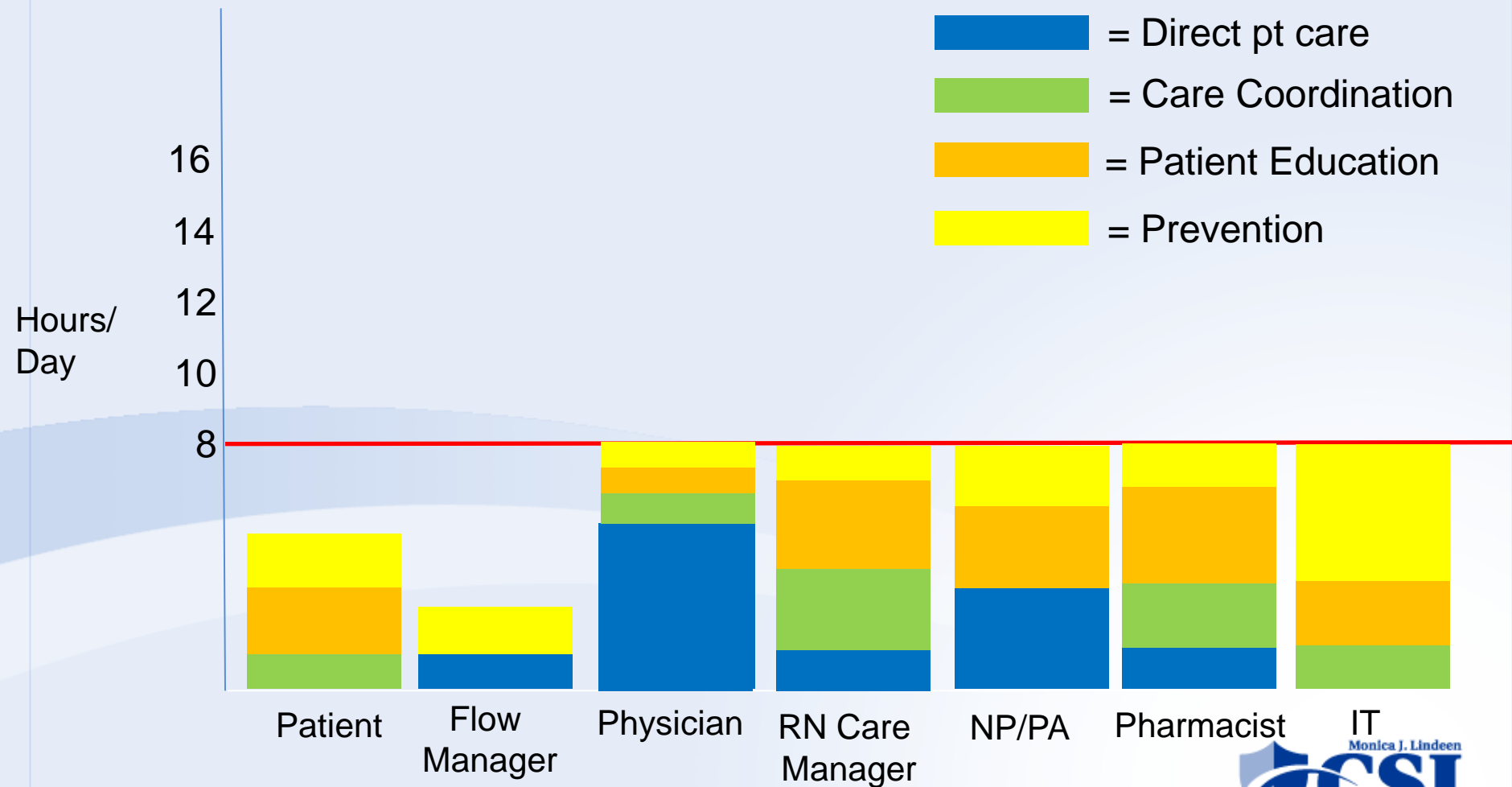
# Meeting the Triple Aim

- This will require a **major transformation or redesign of practice**, not just an EMR and better reimbursement.
- But such transformations will be difficult to implement or or sustain without strong motivation.

# The Ideal Care Model

The goal should be to **transform the relationship** from that which is based primarily on the interaction between one patient and one doctor and his or her nurse to a more efficient, more affordable, healing relationship between a patient and their **primary care team** with the goal of providing personal, full-spectrum, appropriate, compassionate care.

# ***A Better Model of Care...***



# Still this is really hard work?

- Practices are complex, adaptive systems with interdependent processes and systems; a change to one aspect (e.g., a staff role) affects others.
- Medical practice is inherently stressful, and established routines and patterns limit stress even if flawed.
- Transformation to a PCMH asks physicians and other staff to change their roles and identities, the way they deliver care, and how they relate to one another.

# How do we become a PCMH?

“Change is hard enough; transformation to a PCMH requires epic whole-practice reimagination and redesign.”\*

“The magnitude of stress and burden from the unrelenting, continual change required to implement components of the [PCMH] model was immense.”\*\*

\*Nutting et al. Ann Fam Med. 2009; 7:254-260

\*\*Nutting et al. Ann Fam Med. 2010; 8 (Supp 1): S45-S56.

# Primary Care Home

## Health Care Team

Patient  
Physician

And many others may be part of  
the team: NP, PA, Nurse,  
Care Navigator, Office Staff,  
Mental Health Worker  
Pharmacist, EMR

# Does it Really Work?

## QUALITY EXAMPLES



# Genesee Health Plan HealthWorks

- Set-up:
  - Four year longitudinal evaluation of PCMH to serve 25,000 uninsured adults in Flint, Michigan.
  - Team approach to improve health and reduce costs
  - Health Navigator works with primary care clinicians to support patients to:
    - Adopt healthy behaviors
    - Improve chronic and preventive care
    - Link to community resources



# Genesee Health Plan Results

- 72% of all uninsured adults in the county can now identify a primary care practice as their medical home.
- 137% increase in mammography screenings
- 36% reduction in smoking and “improvements in other healthy behaviors.”
- 50% decrease in **ER visits**
- 15% fewer **inpatient hospitalizations**
- Total hospital days per 1,000 enrollees now cited as 26.6% lower than competitors.

# Geisinger Health Plan

- In addition to emphases on team care, outreach, integrated IT, etc, a nurse care manager was embedded in each practice.
- Nurse worked closely with practice team and reviewed case load with a consulting internist who connected them with subspecialists if necessary

# Geisinger Results

- 19% reduction in “all cause” admissions to hospitals, and 39% reduction in readmissions.
- 7% decrease in overall cost.

# Does it Really Work?

## SATISFACTION EXAMPLE AND COST SAVINGS



# Provider Testimonials

# Did the Group Health pilot achieve the quadruple aim?

Patient Experience	Improved patient experience in access, care coordination, chronic illness care.
Staff Burnout	Significant reductions in emotional exhaustion and depersonalization.
Clinical Quality	Significant improvement across 22 quality indicators.
Utilization	PCP visits declined 6% but pt. contact increased by e-mail and phone. Specialty use increased initially. ER and hospital use 29% and 6% less, respectively.
Costs	Total costs \$10.30 pmpm less than control clinics.

# The Montana Patient-Centered Medical Home Advisory Council

- **Created by Commissioner of Securities and Insurance Monica Lindeen**
- **Includes representatives of medical providers, insurance companies, and consumers in the public and private sectors**

## Charges

- gathering information on other PCMH projects across the country to value Montana's efforts
- Recommending procedures and policies for launching a pilot project in Montana
- Recommending a legal structure, governance model, and funding mechanism for an on-going program

# Next Webinars

- Webinar #2 – Dr. Wagner from the MacColl Institute at Group Health Cooperative presents on the Change Concepts for Transformation
- Webinar #3 - NCQA Standards, a guide to recognition for your practice, and resources for change
- Webinar #4 - Framework for Payment, a guide for payer/provider contracts for PCMH
- Webinar #5 - Quality Metrics, benchmarks the council is considering for measuring performance

# Contact info

- [www.csi.mt.gov](http://www.csi.mt.gov)
- 1-800-332-6148
- Resources
- How to join the list serve